Welcome! So that we may provide you with the best possible care, it is important that you tell all dental personnel involved in your treatment about the general state of your health. Please complete this medical history form. This information is, of course, confidential.

Name _____ Age:_____ ◯ Male ◯ Female

Height _____ Weight _____

MEDICAL HISTORY

Name of previous Dentist _____ Last dental visit _____

Name and Address of physician _____

When was your last physical examination? _____

Are you now under the care of a physician? ◯ Yes ◯ No

If yes for what reason? _____

Are you presently taking any medications/drugs/pills? ◯ Yes ◯ No

Please list:

Meds	Reason	Meds	Reason	Meds	Reason

Have you ever taken Fosomax, Acional, Boniva or any other biphosphonate? ◯ Yes ◯ No If yes, how long?_____

Are you ALLERGIC (or have an adverse reaction) to:

☐ Penicillin ☐ Other antibiotics List:_____ ☐ None ☐ Other_____

☐ Aspirin ☐ Codeine ☐ Local Anesthetic ☐ Latex ☐ Sulfa

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING: (Please answer yes or no)

YES	NO		YES	NO		YES	NO		YES	NO		YES	NO	
◯	◯	Heart Disease/Surgery	◯	◯	Tuberculosis	◯	◯	Arthritis/Rheumatism	◯	◯	Tumor	◯	◯	Artificial Joint
◯	◯	Heart Murmur	◯	◯	Lung Disease	◯	◯	Cortisone Medicine	◯	◯	Chemotherapy	◯	◯	Venereal Disease
◯	◯	Heart Pacemaker	◯	◯	Diabetes	◯	◯	Prolonged Bleeding	◯	◯	Radiation Therapy	◯	◯	HIV pos/AIDS/ARC
◯	◯	Rheumatic Fever	◯	◯	Epilepsy	◯	◯	Hemophilia	◯	◯	Stroke	◯	◯	Hearing Impaired
◯	◯	Rheumatic Heart Disease	◯	◯	Anemia	◯	◯	Sickle Cell Disease	◯	◯	Glaucoma	◯	◯	Organ Transplant
◯	◯	Congenital Heart Defects	◯	◯	Chemical Dependency	◯	◯	Fainting Spells	◯	◯	Psychiatric Care	◯	◯	Alcohol Addiction
◯	◯	Artificial Heart Valve	◯	◯	Kidney Problems	◯	◯	Asthma	◯	◯	Anorexia	◯	◯	Drug Dependency
◯	◯	Mitral Valve Prolapse	◯	◯	Hepatitis -	◯	◯	Emphysema	◯	◯	Bulimia	◯	◯	Ulcers
◯	◯	Low / High Blood Pressure			A, B, or C (circle)	◯	◯	Sinus Trouble	◯	◯	Neurological Disorders	◯	◯	Lupus
◯	◯	Fen-Phen	◯	◯	Liver Disease	◯	◯	Cancer	◯	◯	Prosthetic Implants	◯	◯	Other
									◯	◯	Thyroid Disease	_____		

Do you currently smoke or use the following tobacco products?

☐ cigarettes ☐ cigars ☐ pipe ☐ chew ☐ none

Have you used tobacco products in the past? ◯ Yes ◯ No If yes, how long ago? _____

Do you drink alcoholic beverages? ◯ Yes ◯ No If yes, how much? _____

WOMEN: Are you pregnant? ◯ Yes ◯ No If yes, how far along are you? _____

Do you take birth control medications? ◯ Yes ◯ No

Have you had any other serious illness, hospitalization or accident? ◯ Yes ◯ No If yes, please explain? _____

DR COMMENTS

_____ _____

DR. SIGNATURE DATE

B.P. _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify my dentist of any changes in my health or medication.

Patient signature (parent or guardian of a minor)_____ Date _____

NAME_____ # _____ **MEDICAL HEALTH HISTORY**

DENTAL HISTORY

What is the reason for your visit today? _____

Previous Dentists Name _____ Address _____

Date of last Visit _____ last Hygiene Visit _____

Why did you leave your last Dentist? _____

How often do you have dental examinations? _____

How often do you brush your teeth? _____ How often do you floss? _____

What other aids do you use? (electric toothbrush, toothpick, etc) _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe _____

ARE ANY OF YOUR TEETH SENSITIVE TO:

Hot or Cold . . . . . ☐ Yes ☐ No
Sweets? . . . . . ☐ Yes ☐ No
Biting or pressure? . . . . . ☐ Yes ☐ No
Have you ever notice any mouth odors
or bad taste? . . . . . ☐ Yes ☐ No
Do you frequently get cold sores,
blisters or any lesions? . . . . . ☐ Yes ☐ No

DO YOUR GUMS BLEED OR HURT? . . . . . ☐ Yes ☐ No
Have your parents experienced
gum disease or tooth loss? . . . . . ☐ Yes ☐ No
Have you notice any loose teeth or
change in your bite . . . . . ☐ Yes ☐ No
Does food tend to become caught
between your teeth? . . . . . ☐ Yes ☐ No

DO YOU:

Clench or grind your teeth while
awake or asleep? . . . . . ☐ Yes ☐ No
Have tired jaws, especially in the morning . . ☐ Yes ☐ No
Bite your lips or cheeks regularly? . . . . . ☐ Yes ☐ No
Hold foreign objects with your teeth?
(pencils, pins, nails, fingernails, pipe) . . ☐ Yes ☐ No
Mouth breath while asleep or awake . . . . . ☐ Yes ☐ No
Do you (or a family member) snore
or have sleep apenea? . . . . . ☐ Yes ☐ No

HAVE YOU EVER EXPERIENCED:

Clicking or popping of the jaw? . . . . . ☐ Yes ☐ No
Pain (Joint, ear, side of face) . . . . . ☐ Yes ☐ No
Difficulty opening or closing the mouth? . . . ☐ Yes ☐ No
Frequent headaches neck aches, or
shoulder aches? . . . . . ☐ Yes ☐ No
Any pain or soreness in the muscles of
your face or around the ears? . . . . . ☐ Yes ☐ No

HAVE YOU EVER HAD:

Orthodontic treatment? . . . . . ☐ Yes ☐ No
Oral Surgery? . . . . . ☐ Yes ☐ No
Teeth removed? . . . . . ☐ Yes ☐ No
If so, have they been replaced? . . . . . ☐ Yes ☐ No
Fixed Bridge? . . . . . ☐ Yes ☐ No
Removable Partial? . . . . . ☐ Yes ☐ No
Complete Denture? . . . . . ☐ Yes ☐ No
Implants? . . . . . ☐ Yes ☐ No
Are you happy with the replacement . . . . . ☐ Yes ☐ No
Periodontal Treatment? . . . . . ☐ Yes ☐ No
Gum Surgery? . . . . . ☐ Yes ☐ No
If yes, when . . . . . _____
By whom? . . . . . _____
Your teeth ground or the bite adjusted? . . . ☐ Yes ☐ No
A serious injury to the mouth or head? . . . . ☐ Yes ☐ No
If yes, please describe. Include cause. . . _____
_____
_____

**Are you dissatisfied with the
appearance of your teeth?** . . . . . ☐ Yes ☐ No
Are your teeth discolored? . . . . . ☐ Yes ☐ No
Are your teeth crooked? . . . . . ☐ Yes ☐ No
Would you like to change the appearance
of your teeth? . . . . . ☐ Yes ☐ No

Do you feel anxiety about having
dental treatment? . . . . . ☐ Yes ☐ No
Have you ever had an upsetting
dental experience? . . . . . ☐ Yes ☐ No

If yes please describe _____
_____
_____
How did you overcome your anxiety? _____
_____
_____

IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW? _____